ADAP - COVERED CALIFORNIA 2015 FORMULARY (ARV AND HEPATITIS C DRUGS) COMPARISON CHART

The review of Covered California health plan formularies for 2015 was completed by OA staff on January 22, 2015 and therefore may not reflect changes that have occurred to a plan formulary after that review date. Please click on the web linked plan name below (links to each plan's offical formulary) to view full formulary information including drug tier information, possible mail-order requirements ** and other important information you made need to make an informed plan decision. ADAP will only cover co-pays for drugs listed on the ADAP formulary that are dispensed through a pharmacy that is an in-network pharmacy for both the Covered California health plan and ADAP.

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ADAP FORMULARY ANTIRETROVIRAL AND HEPATITIS C DRUGS			ANTHEM BLUE CROSS WELLPOINT	MOLINA HEALTH CARE	<u>VALLEY</u> <u>HEALTH</u> <u>PLAN</u>	LA CARE HEALTH PLAN	CHINESE COMMUNITY HEALTH PLAN	BLUE SHIELD OF CALIFORNIA	HEALTH NET	KAISER PERMANENTE	SHARP HEALTH PLAN	WESTERN HEALTH ADVANTAGE
Pink colored boxes indicate that the specific plan formu	lary does not incl	ude the ADAP drug listed. NOTE: Th	nese Covered Calij	fornia health pi	ans must have	procedures in	place that allow a	n enrollee to red	quest and gain a	access to clinically	appropriate dru	gs not covered
by the health plan.												
GENERIC	BRAND	ADAP RESTRICTIONS										
NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITOR	S											
abacavir	Ziagen		X	X	X	X	X	X	X	X	X	X
abacavir/lamivudine	Epzicom		X	X	X	X	X	X	X	X	X	X
abacavir/lamivudine/zidovudine	Trizivir		X		X	X	X	X	X	X		X
delavirdine	Rescriptor		X	X	X	X	X	X	X	X	X	
didanosine	Videx, Videx EC		x	X	X	X	X	x	x	X	x	X
efavirenz	Sustiva		X	X	X	X	X	X	X	X	X	X
emtricitabine	Emtriva		X	X	X	X	X	X	X	X	X	
lamivudine	Epivir	Epivir HB not covered	X	X	X	X	X	X	X	X	X	X
stavudine	Zerit		X	X	X	X	X	X	X	X	X	
NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIB	BITORS											
tenofovir disoproxil fumarate	Viread		X	X	Χ	X	X	X	X	X	X	X
tenofovir/emtricitabine	Truvada		X	X	X	X	X	X	X	X		X
zidovudine	Retrovir		Х	X	X	X	X	Х	X	X	Х	
zidovudine/lamivudine	Combivir		X	X	X	X	X	X	X	X	X	X
etravirine	Intelence		X	X	X	X	X	X	X	X	X	X
nevirapine	Viramune		X	X	X	X		X	X	X	X	X
rilpivirine	Edurant		X	X	X	X	X	X	X	X	X	
FUSION INHIBITORS												
enfuvirtide	Fuzeon	Requires Prior Authorization	X	X	X	X	X	X	X	X		X
COMBINATION TREATMENT												
elvitegravir/cobicistat/emtricitabine/tenofovir	Stribild			X	X	X	X		X	X		
emtricitabine/tenofovir/efavirez	Atripla		X	X	X	X	X		X	X		X
emtricitabine/tenofovir/rilpivirine	Complera			X		X	X		X	X		X
dolutegravir/lamivudine/abacavir	Triumeq				X	X	X		X			
PROTEASE INHIBITORS												
atazanavir	Reyataz		X	X	X	X	X	X	X	X	X	X
darunavir (TMC-114)	Prezista		X	X	X	X	X	X	X	X	X	X

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			<u>ANTHEM</u>	MOLINA	<u>VALLEY</u>	LA CARE	<u>CHINESE</u>	BLUE SHIELD		MAICED	<u>SHARP</u>	WESTERN
ADAP FORMULARY ANTIRETROVIRAL AND HEPATITIS C DRUGS			BLUE CROSS	<u>HEALTH</u>	<u>HEALTH</u>	<u>HEALTH</u>	<u>COMMUNITY</u>	<u>OF</u>	HEALTH NET	KAISER PERMANENTE	<u>HEALTH</u>	<u>HEALTH</u>
			WELLPOINT	<u>CARE</u>	<u>PLAN</u>	<u>PLAN</u>	<u>HEALTH PLAN</u>	<u>CALIFORNIA</u>		PERIVIAINENTE	<u>PLAN</u>	<u>ADVANTAGE</u>
Pink colored boxes indicate that the specific plan formulary does not include the ADAP drug listed. NOTE: These Covered California health plans must have procedures in place that allow an enrollee to request and gain access to clinically appropriate drugs not covered												
by the health plan.												
GENERIC	BRAND	ADAP RESTRICTIONS										
PROTEASE INHIBITORS (Continued)												
fosamprenavir	Lexiva		X	X	X	X	X	X	X	X	X	X
indinavir	Crixivan		X	X	X	X	X	X	X	X	X	
lopanavir/ritonavir	Kaletra		X	X	X	X	X	X	X	X	X	X
nelfinavir	Viracept		X	X	X	X	X	X	X	X	X	
ritonavir	Norvir		X	X	X	X	X	X	X	X	X	X
saquinavir mesylate	Invirase		X	X	X	X	X	X	X	X		
tipranavir	Aptivus		X	X	X	X	X	X	X	X		
CCR5 CO-RECEPTOR ANTAGONISTS												
maraviroc	Selzentry	Requires Prior Authorization	X	X	X	X	X	X	X	X		X
INTEGRASE INHIBITOR												
raltegravir	Isentress		X	X	X	X	X	X	X	X	X	X
dolutegravir	Tivicay				X	X	X		X	X		X
BOOSTING AGENT		_				1						
cobicistat	Tybost								X		X	
HEPATITIS C DRUGS												
	Peg-Intron,		v				v			V	V	v
pegylated interferon	Pegasys	Requires Prior Authorization	X	X	X	X	X	X	X	X	X	X
	Rebetol,		V	V	V	V	V	V	V	V	V	V
ribavirin	Copegus		X	X	X	X	X	X	X	X	X	X
simeprevir	Olysio	Requires Prior Authorization			X	X	X		X			X
sofosbuvir	Sovaldi	Requires Prior Authorization			X	X	X		X	X		X
Additional Covered California Health Plan Formulary Information:												
			As generic drugs				l					
		How often is the formulary updated?		Quarterly	Monthly	Quarterly	Monthly	Quarterly	Monthly	Quarterly	Quarterly	Monthly
Are Members notified when changes		Members notified when changes occur?	Yes, affected members notified	No, members need to review the web formulary for changes	Yes, affected members notified and web updated	No, members not currently notified of changes	Yes, affected members notified and web updated	Announced on the "Formulary Changes" link of the web page	Yes, affected members notified	Yes, affected members notified	No, members need to review the web formulary for changes	No, members need to review the web formulary for changes

^{**}To opt out of Anthem Mail Order Services, contact Express Scripts at (877) 536-4320. **To opt out of Blue Shield Mail Order Services, contact Customer Service - number on the back of the Member ID Card.